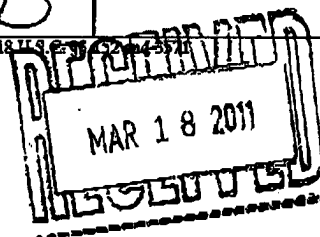


B10 (Official Form 10) (04/10)

| UNITED STATES BANKRUPTCY COURT Northern District of New York | | PROOF OF CLAIM |
|--|--|--|
| Name of Debtor: Jonathan E. Fuller Carrie L. Fuller | | Case Number: 10-32160-5-mcr |
| NOTE: This form should not be used to make a claim for an administrative expense arising after the commencement of the case. A request for payment of an administrative expense may be filed pursuant to 11 U.S.C. § 503. | | |
| Name of Creditor (the person or other entity to whom the debtor owes money or property): Neonatal Associates of CNY | | <input type="checkbox"/> Check this box to indicate that this claim amends a previously filed claim. Court Claim Number: _____ (If known) Filed on: _____ |
| Name and address where notices should be sent: Neonatal Associates of CNY 736 Irving Ave Rm 9100 Syracuse, NY 13210-1687 | | |
| Telephone number: _____ | | <input type="checkbox"/> Check this box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars. <input type="checkbox"/> Check this box if you are the debtor or trustee in this case. |
| Name and address where payment should be sent (if different from above): OFFICE OF THE BANKRUPTCY CLERK SYRACUSE, NY | | |
| Telephone number: 315-420-7009 | | 5. Amount of Claim Entitled to Priority under 11 U.S.C. § 507(a). If any portion of your claim falls in one of the following categories, check the box and state the amount. Specify the priority of the claim. <input type="checkbox"/> Domestic support obligations under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B). <input type="checkbox"/> Wages, salaries, or commissions (up to \$11,725*) earned within 180 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(6). <input type="checkbox"/> Contributions to an employee benefit plan - 11 U.S.C. § 507(a)(5). <input type="checkbox"/> Up to \$2,600* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(7). <input type="checkbox"/> Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8). <input type="checkbox"/> Other - Specify applicable paragraph of 11 U.S.C. § 507(a)(____). Amount entitled to priority: \$ _____ |
| 1. Amount of Claim as of Date Case Filed: \$40.00 | | |
| If all or part of your claim is secured, complete item 4 below; however, if all of your claim is unsecured, do not complete item 4. If all or part of your claim is entitled to priority, complete item 5. <input type="checkbox"/> Check this box if claim includes interest or other charges in addition to the principal amount of claim. Attach itemized statement of interest or charges. | | |
| 2. Basis for Claim: <u>Career on Insurance Claims</u> (See instruction #2 on reverse side) | | *Amounts are subject to adjustment on 4/1/13 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment. |
| 3. Last four digits of any number by which creditor identifies debtor: _____ | | |
| 3a. Debtor may have scheduled account as: _____ (See instruction #3a on reverse side.) | | Amount entitled to priority: \$ _____ |
| 4. Secured Claim (See instruction #4 on reverse side.) Check the appropriate box if your claim is secured by a lien on property or a right of setoff and provide the requested information. Nature of property or right of setoff: <input type="checkbox"/> Real Estate <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Other Describe: _____ Value of Property: \$ _____ Annual Interest Rate: _____ % Amount of arrearage and other charges as of time case filed included in secured claim, if any: \$ _____ Basis for perfection: _____ Amount of Secured Claims: \$ _____ Amount Unsecured: \$ _____ | | |
| 6. Credits: The amount of all payments on this claim has been credited for the purpose of making this proof of claim. | | Amount entitled to priority: \$ _____ |
| 7. Documents: Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. You may also attach a summary. Attach redacted copies of documents providing evidence of perfection of a security interest. You may also attach a summary. (See instruction 7 and definition of "redacted" on reverse side.) DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING. If the documents are not available, please explain: _____ | | |
| Date: 3/24/11 Signature: The person filing this claim must sign it. Sign and print name and title, if any, of the creditor or other person authorized to file this claim and state address and telephone number if different from the notice address above. Attach copy of power of attorney, if any. <u>Jonathan E. Fuller</u> | | FOR COURT USE ONLY |

Penalty for presenting fraudulent claim: Fine of up to \$500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. § 1592.



Neonatal Associates Of CNY

736 Irving Ave

Room 9100

Syracuse, NY 13210

03/21/11

\$20.00

24820

STATEMENT

|||||

Fuller, Carrie L

100 South Terry Rd

Syracuse, NY 13219

Neonatal Associates Of CNY

736 Irving Ave

Room 9100

Syracuse, NY 13210

(315) 470-7009

Twin A

| DATE | DESCRIPTION OF SERVICE | AMOUNT | INSUR BALANCE | PATIENT BALANCE | BALANCE |
|----------|--|-----------|------------------|--------------------|---------|
| 02/23/10 | ENCOUNTER 63841 FOR TYLER WITH BODE MD, MICHELLE M | | | | |
| 02/23/10 | 99244 - Clinic Office Visit | \$350.00 | | \$20.00 | |
| 03/18/10 | BC/BS Payment (3 (Copayment Applied)) | -\$189.63 | | | |
| 03/18/10 | BC/BS Adjustment (3 (Copayment Applied)) | -\$140.37 | | | |
| 08/18/10 | Bankruptcy | -\$20.00 | | | |
| 03/21/11 | Adjustment Positive | \$20.00 | | | |
| | ENCOUNTER TOTAL | \$20.00 | \$0.00 | \$20.00 | \$20.00 |

| ACCOUNT NBR | CURRENT | 30 DAYS | 60 DAYS | 90 DAYS | 120 DAYS | TOTAL ACCOUNT BALANCE |
|-------------|---------|---------|---------|---------|----------|-----------------------|
| 24820 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$20.00 | \$20.00 |

MESSAGE:

CREDIT CARDS ARE NOW BEING ACCEPTED.

| |
|--|
| PLEASE PAY THIS AMOUNT >>>> \$20.00 |
|--|

** PAYMENT DUE UPON RECEIPT * THANK YOU **
STATEMENT



Excelius

105 Court Street Rochester, NY 14647

PHYSICIAN REMITTANCE SUMMARY

PROVIDER ID 1205250271 NEONATAL ASSO OF ONY PO
736 IRVING AVE RM 8105
SYRACUSE NY 13210

PROCESS DATE/TIME' .. PAGE

09/18/2010 04:14

[illegible]

Neonatal Associates of Central New York, PC**PATIENT CONSENT FORM**

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, and/or health care operations.

As our patient we want you to know that we respect the privacy of your personal health information (PHI) and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your PHI, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your PHI. If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

In the event your account were to go to collections for lack of payment, you will be responsible for any and all collection and/or attorney fees.

Carrie L Fuller

Signature

6-9-09

Date

Carrie L Fuller

Print Name

10/18/09 11:07 AM

10/18/09 11:07 AM

24820

(315) 470-7009

Twin B

**PLEASE PAY
THIS AMOUNT »»»» \$20.00**

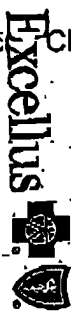
PAGE: 1

165 Court Street, Rochester, NY 14647

PROVIDER ID 1220250271
NEONATAL ASSOC OF CNY PO
738 TRYING AVE RM 9100

PHYSICIAN REFITTANCE SUMMARY

PROCESS DATE/TIME PAGE
03/16/2010 04:14



| SUBSCRIBER ID | PATIENT NAME | PATIENT ACCOUNT # | PROCEDURE CODE | SERVICE START | SERVICE END | CLAIMS CHARGES | ALLOWED AMOUNT | BENEFIT ALLOWANCE | REIMBURSED AMOUNT | PATIENT LIAB |
|----------------|--------------|-------------------|----------------|---------------|-------------|---|----------------|-------------------|-------------------|--------------|
| 7FA118BP3214-3 | LAST/FIRST | | | | | | | | | |
| 80070852420 | EMMA | 001200063842 | 99244 | 02/23/10 | 02/23/10 | 380.00 PRIOR AT CNY SCHEDULE OF ALLOWANCES REDUCED BY COPAYMENT | 209.83 | 209.83 | 188.83 | 20.00 |
| CLAIM TOTAL | | | | | | | | | | |
| 380.00 | | | | | | | 209.83 | 209.83 | 188.83 | 20.00 |
| 7FA118BP9214-3 | FULLER | 001200063841 | 99244 | 02/23/10 | 02/23/10 | 380.00 PRIOR AT CNY SCHEDULE OF ALLOWANCES REDUCED BY COPAYMENT | 209.83 | 209.83 | 188.83 | 20.00 |
| 80070852480 | TYLER | | | | | | | | | |
| CLAIM TOTAL | | | | | | | | | | |
| 380.00 | | | | | | | 209.83 | 209.83 | 188.83 | 20.00 |
| **PAID** | | | | | | | | | | |
| CLAIM TOTAL | | | | | | | | | | |
| 380.00 | | | | | | | 209.83 | 209.83 | 188.83 | 20.00 |

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Signature

6-9-09

Date

Carrie L Fuller

Print Name